

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005859

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 100

Primary Registration District No. _____

Registrar's No. 18

STATE FILE NUMBER

FILED FEB 25 1963

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u>		c. CITY OR TOWN <u>Salem</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hart Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Henderson St</u>
3. NAME OF DECEASED (Type or print) First <u>Earnest</u> Middle <u>Asher</u> Last _____		4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1963</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-82</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>street car worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Dent Co Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>James Asher</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Asher</u>		14. NAME OF HUSBAND OR WIFE <u>Bertie Asher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>unknown</u>) (If yes, give war or dates of _____)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Bertie Asher</u>		Address <u>Salem Mo</u>	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>GENERALIZED Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>a few hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>8</u> <u>1957</u> to <u>Feb. 1963</u> and last saw ^{him} alive on <u>2/22/63</u> Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. J. Bass</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Salem, Mo.</u>	22c. DATE SIGNED <u>2/23/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-24-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cavenough Cem</u>	23d. LOCATION (City, town, or county) <u>Dent County Mo</u>
24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u>		25. DATE RECD. BY LOCAL REG. <u>2.23.63</u>	26. REGISTRAR'S SIGNATURE <u>M. M. Hart, MD by AM.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/591 02312 02313 24 05 1

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. R. D. Jones

Licensed Embalmer No.

2376

P. O. Address

Staten Island

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.